STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325035	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Vida Llena	10501 Lagrima DE Oro NE Albuquerque, NM 87111

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation ,and record review, the facility failed to protect 1 (R #1) of 1 (R #1) resident from exploitation and misappropriation of property by a sales consultant (SC) at a sister facility (a facility owned by the same company) who fraudulently obtained a $1,569 refund for R #1's hearing aids after her death. If the facility fails to prevent employees from misusing their positions to access and exploit resident financial information, then residents are at risk for financial harm. The findings are: A. Record review of the facility's Abuse Prevention Policy, dated 05/2024, revealed the following: - All forms of exploitation and financial abuse were prohibited, to include misappropriation of resident property. - Staff to report all suspected abuse immediately Administrator, Director of Nursing, or their designee. - Any staff involved in such allegations will be removed from their assigned duties, pending the outcome of the investigation, pending investigation. B. On [DATE] at 8:00 am, observation of the campus revealed the campus had an independent living facility, an assisted living facility, and a skilled nursing facility. Visitors did not need to sign a log to show they were in the facility and who they visited. Further observation revealed, staff and visitors could move freely throughout the three facilities. C. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated [DATE], revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 00, severe cognitive impairment. D. Record review of R #1's medical record revealed the following: - admission date of [DATE] to the Skilled Nursing facility. - Diagnoses of metabolic encephalopathy (any disease or disorder which affects the brain's function or structure), altered mental status, and congestive heart failure. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The name and contact information for three emergency contacts: Power of Attorney for Finance (POA-F; a person legally authorized to manage another individual's financial matters), Power of Attorney for Health Care (POA-HC), and another emergency contact (The emergency contact was not an employee of the facility or the corporation.) E. Record review of R #1's progress notes revealed the following: - Dated [DATE], resident was on her second day of admission. She was hard of hearing. The resident was very confused. - Dated [DATE] psychiatric evaluation. The resident came from the Assisted Living facility/Independent Living facility due to altered mental status. On [DATE], the resident was found wandering and was brought back to the facility. Facility staff requested a psychiatric evaluation and reported the resident was unstable. They reported the resident experienced confusion, anxiety, agitation, and disorganization. The resident had a comprehensive workup, but her confusion was ongoing and consistent with dementia. Assessment and Plan: altered mental status related to dementia and at risk of depression. - Dated [DATE], at 10:07 am communication with physician: the resident was lethargic, responded to her name and then went back to sleep. At 10:48 am, received verbal orders from the on-call provider to send the resident to the emergency room (ER) for evaluation and treatment. At 1:57, staff notified POA of the resident's condition and the ambulance arrived to take the resident to the hospital. - Dated [DATE], resident admitted to the hospital. - Dated [DATE], at 10:45 pm, resident was readmitted to the facility and was nonresponsive. - Dated [DATE], resident on hospice with comfort measures. At 8:02 pm, resident was visited by a POA. - Dated [DATE], resident was visited by her brother. - Dated [DATE], Resident's friend (did not state who) stepped out of the resident's room to request a nurse. Resident pronounced deceased at 4:05 pm. - Dated [DATE], Social Worker called R #1's POA-F regarding resident's purse was in the Social Services safe. F. Record review of documentation from an outside company where R #1 had a hearing aid fitting appointment revealed the following: - Internal note, dated [DATE] at 10:15 am, R #1 had an appointment and purchased new hearing aids. Fitting appointment scheduled in two weeks. - Internal note, dated [DATE] at 12:00 pm, member's grandson called to advise that R #1 was not feeling well and could not make it to the fitting appointment. The resident had heart failure and was on hospice. Grandson asked if the outside company could dispense the hearing aids without a measurement or the resident present. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Internal note, dated [DATE] at 5:30 pm, R #1 passed away before returning for fitting. Return of the purchased hearing aids to be processed by the outside company. - Receipt, dated [DATE] at 5:41 pm, the store issued a $1,569 refund for R #1's hearing aids. - Internal note, dated [DATE] at 3:30 pm, R #1's legal guardian (POA- HC) contacted the store to cancel R #1's hearing aid appointment. Store staff informed the guardian that R #1's grandson already canceled the appointment and processed the refund. The guardian stated they were unfamiliar with the grandson and requested more information. Store staff provided to the legal guardian the name and contact information of SC #1, who told the outside company he was R #1's grandson. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On [DATE] at 12:38 pm and on [DATE] at 12:38 pm,, during an interview, R #1's POA-F stated R #1 used to be her own responsible party, but she became R #1 POA-F about in the Spring of 2024. She stated an anonymous staff alerted her around (did not remember exact date) that SC #1 purchased R#1's private residence under suspicious circumstances in [DATE]. She stated SC #1 had access to R #1's personal financial and social information through the Independent Living facility's intake process, and SC #1 used this knowledge to take advantage of R #1's vulnerability. The POA-F stated she called R #1, and the resident said she felt like she was isolated from her trusted financial and legal advisors and was discouraged from contacting them during the sale of her house. The POA-F stated she was not aware the resident's house was for sale, so she conducted research regarding the sale. She stated she found the paperwork for the sale of the house, and it showed SC #1 bought R #1's house for less than market value. She stated the resident was charged over $25,000 in closing fees from the sale of the house. The POA-F stated she believed the sales money was deposited into R #1's personal bank account. She stated could not verify the money was deposited in the resident's personal bank account, because she could not yet access that account. She stated the facility staff told her the sale of the house was approved by the corporation who owned the Independent Living and the Skilled Nursing facilities. She stated she was told the entire chain of command at the corporation and the Independent Living facility approved the sale. The POA-F stated she was not informed the house was for sale, but she expected to be notified. She stated the resident signed paperwork during the sale of the house, but she most likely signed it because she was told to sign it. She stated she met with R #1 a couple times a year, and she did not believe the resident fully understood what was happening. She stated the R #1 did not have the level of understanding to comprehend the settlement statements and representation during the sale of her house. She stated the resident was vulnerable and easily manipulated. The POA-F stated the resident was on Medicare, and the facility knew how much money the resident had. She stated the resident did not need to sell anything in order to move from the Independent Living facility into the Skilled Nursing facility, because R #1 had plenty of money. She stated there was not a reason for the resident to sell her house below market value. The POA-F stated she contacted the real estate agent who assisted with the sale of R #1's house. She stated the real estate agent became very angry and refused to speak to her. The POA-F stated she went to the visit R #1 at the Skilled Nursing facility three or four days before her death. She stated the resident was asleep when she arrived at the facility. She stated the resident could not hear and preferred to receive text messages. The POA-F stated she texted the resident a message to let her know she stopped by to see her. The POA-F stated the resident's cell phone was on her bedside table, and she saw the message come into the resident's phone. She stated the facility called her after R #1's death and said the resident's belongings were ready for pickup. The POA-F stated the resident's phone was not with her personal belongings. She stated the facility told her they could not find R #1's cell phone. The POA-F stated she still has not received R #1's cell phone. The POA-F stated she was not present at the facility when R #1 passed away, and she knew the POA-HC was not present at the facility at that time. The POA-F stated R #1 did not have any friends, and she did not know who the friend was present in the room when R #1 passed away. R #1's POA-F stated she learned of the hearing aid refund from R #1's POA-HC. She stated the POA-HC called the outside company to cancel R #1's hearing aid fitting appointment, and the outside company told him R #1's grandson already canceled the appointment and collected the refund. The POA-F stated POA-HC asked for more information about the grandson, and the outside company gave him SC #1's contact information. The POA-F stated she contacted SC #1 after she learned SC #1 deposited the $1,569 refund into his personal account rather than R #1's estate account. She stated SC #1 initially denied any knowledge of the refund. She stated SC #1 called her back several days later and admitted to collecting the refund. The POA-F stated she received a cashier's check from SC #1 by certified mail, but the check was made out to the wrong entity. SC #1 stated she was unable to cash the check. The POA-F stated SC #1 mailed the cashier's check without contacting her first, and that was why the information on the cashier's check was incorrect. The POA-F stated she did not contact the facility regarding the hearing aid refund, because she thought the online complaint report (for the State Agency) went to the facility. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. Record review of the home selling/buying website on which R #1's house was listed for sale revealed the resident's house was listed at $353,800 and was sold. I. Record review of R #1's Title Company Record of Sale for R #1's house, settlement date [DATE] and reimbursement date [DATE], revealed the following: - The seller of the house was R #1, Trustee of the R #1 revocable trust dated [DATE]; - The buyer of the house was SC #1 and one female. - Sale price of property $275,000. - The seller paid $25,082.17 in various fees. - The seller received $249, 917 for her house. J. Record review of R #1's Inventory of Personal Effects, dated [DATE], revealed the resident had one cell phone on admission to the facility. K. On [DATE] at 11:45 am, during an interview with the Executive Director, R #1's Life Care Plan [long term care service which residents can purchase which allows them to move between the levels of care (independent, assisted, skilled) as required by their medical needs] and medical record from the Independent Living facility was requested. The Executive Director stated R #1 lived in the Independent Living facility, and the Life Care Plan was a part of her records for that facility. The Executive Director stated R #1's Life Care Plan and medical record while at the Independent Living facility did not have anything to do with the resident's time at the Skilled Nursing facility. He stated the facility did not have any banking documents or statements for R #1 for her time at the Skilled Nursing facility. The Executive Director did not provide R#1's Life Care Plan, medical, and financial records from the Independent Living facility. L. On [DATE] at 12:20 pm and on [DATE] at 2:00 pm, during an interview, the Social Worker stated she was responsible to coordinate the communication with hospitals during resident discharges and admissions, to oversee the Social Services Department, and served as the facility's Admissions Administrator. She stated R #1 moved onto the campus as a resident in the Independent Living facility in [DATE]. She stated R #1 invested in the Life Care Plan while living at the Independent Living Facility. She stated SC #1 assisted R #1 with admission into Independent Living facility and with the purchase of her Life Care Plan in [DATE]. She stated R #1 lived in the Independent Living facility, went to the hospital, and then admitted into the Skilled Nursing facility. She stated R #1 moved to the Long Term Care facility on [DATE]. She stated she spoke with the discharging hospital when R #1 transferred from the Independent Living facility to the Skilled Nursing facility. The Social Worker stated the hospital staff referred to R #1's nephew, and they clarified the nephew was SC #1. The Social Worker stated SC #1 was not R #1's nephew. She stated the only staff who should speak to the hospital were the Social Worker, Administrator, or the Director of Nursing (DON). The Social Worker stated she did not know if anyone reported the hospital staff's statement to the Administration. She stated she might have mentioned it to someone, but she could not remember if she did or who she would have told. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	M. On [DATE] at 12:25 pm, during an interview, SC #1 stated he currently worked at the facility as a Sales Consultant at the Independent Living facility, and he was familiar with R #1. He stated he and R #1 developed a close friendship during her time at the facility. He stated he met R #1 in [DATE], and he quickly became friends with her. He stated R #1 asked him to buy her house in [DATE], and he decided that it was a good idea. He stated the Executive Administrator was aware of the purchase of the resident's home. He stated R #1 did not have any known family. He stated R #1 passed away in [DATE]. He stated he went to the outside company (where R #1 had a hearing aid fitting appointment) on [DATE], and he received a $1,569 refund deposited to his personal bank account for R #1's hearing aides. He stated he helped R #1 arrange the original purchase of the hearing aides, and he believed he acted in good faith by retrieving the refund. He stated he did not notify the facility's administration that he was going to return the hearing aides for a refund, and he stated he did not request direction from the facility's administration regarding how to handle the resident's property. SC #1 stated he mailed a reimbursement check to R #1's estate in [DATE]. He stated he communicated with the outside company before and after R #1's death regarding the canceled hearing aid order and refund. He stated he identified himself to the outside company as R #1's grandson in order to facilitate the return and refund process. N. Record review of SC #1's receipt, dated [DATE], revealed SC #1 sent a $1,569.95 cashiers' check to R #1's POA-F by certified mail. O. On [DATE] at 12:47 pm, during an interview, an Anonymous Staff stated he first met R #1 in [DATE] when the resident moved into the Independent Living facility. The Anonymous Staff stated a couple months later, R #1 told him that SC #1 bought her house in [DATE], and the resident stated He took my house. He took my house. The Anonymous Staff stated he looked up the house on a home selling/buying website and noted the market value of the house was $353,800. He stated he did his own research and found out the house was never on the market. The Anonymous Staff stated he did not mention this conversation to anyone, because he was a new employee in the Independent Living facility at the time. The Anonymous Staff stated on another occasion (did not remember the date) the resident was still living in the Independent Living facility, and her call light went off. The Anonymous Staff stated he went into R #1's apartment and found SC #1 in there with R #1. He stated SC #1 asked him to check on the resident, because he did not think the resident looked well. The Anonymous Staff stated he checked R #1, and she exhibited some confusion but was fine. The Anonymous Staff stated shortly after the incident the resident went to the hospital, and he called the hospital to check on the resident. He stated the hospital staff asked if he was the resident's POA, SC #1. The Anonymous Staff stated he was alarmed by this question so he brought his concerns to the Human Resource Director (HRD) and the Executive Director. He stated he told them R #1 reported SC #1 took her house from her. The Anonymous Reporter stated he felt uneasy, because his training as a Registered Nurse and a Mandated Reporter emphasized the importance of these concerns and how exploitation can occur. He stated the HRD and the Executive Director said Corporate staff said all was okay with the sale of the house. The Anonymous Staff stated the resident moved to the Skilled Nursing facility when she returned from the hospital. He stated he spoke to the Skilled Nursing facility's Social Worker (SW), and he told the SW about the hospital staff asking him if he was SC #1, the resident's POA. He stated the skilled nursing facility's Social Worker stated she also had a conversation with the hospital, and the hospital also told her SC #1 was R #1's nephew. The Anonymous Staff stated he was aware he was a mandated reporter and he should have reported the information to the appropriate authorities. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P. On [DATE] at 2:30 pm and on [DATE] at 2:40 pm, during an interview, the Executive Director stated SC #1 worked as a Sales Consultant on the Independent Living facility side of the campus, and he was aware SC #1 purchased R #1's home in [DATE]. He stated the transaction was reported internally and investigated to ensure it was conducted by an external [NAME] and not through facility influence. The Executive Director stated it would be a concern for an employee to purchase property from a resident of the facility, so it was expected such matters would be handled with full transparency and external oversight. He stated he did not have the facility's investigation records of R #1 home sale, and the records were most likely stored at the corporate level. The Executive Director stated the sale of R #1's home was not relevant to her time at the Skilled Nursing facility, because it occurred while she was a resident at the Independent Living facility. The Executive Director stated residents sell their homes all the time to live in the facility. The Executive Director stated he did not know who the hospital contacted at the facility, because R #1 went to the hospital when she lived in the Independent Living facility. The Executive Director stated the facility's Internal Home Health Team followed up on any residents in the hospital. He stated the Internal Home Health Team coordinated services if the resident needed to go to the Skilled Nursing facility. He stated the team did not provide the hospital updates about the residents' POA matters. The Executive Director stated the hospital contacted whoever was listed as R #1's POA in her medical record. He stated he was not aware SC #1 was listed as the emergency contact/POA for R #1 while at the hospital, and he said it was not his expectation for SC #1 to be listed as R #1's emergency contact/POA. The Executive Director stated it was not his expectation for any staff from the Skilled Nursing facility or the Independent Living facility to be listed as a resident's emergency contact or Power of Attorney. The Executive Director stated he was not aware SC #1 collected $1569 for R #1's hearing aids and deposited the money into his personal bank account. He stated it was not his expectation staff would collect any money for a resident unless they were authorized, such as the Social Worker. He stated if SC #1 did collect R #1's money, then it would trigger a facility investigation involving the Corporate Compliance Team, Legal Counsel, and possibly Adult Protective Services. The Executive Director stated the facility did not require visitors to sign-in in order to enter the skilled nursing facility. He stated there were not any visitor logs to show who visited the residents during their stay. The Executive Director refused to provide R #1's records while she was a resident at the Independent Living facility, because it did not have anything to do with R #1's time at the Skilled Nursing facility